STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001148	A. BUILDING: _____ B. WING _____	C 11/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD RIDGE ASSISTED LIVING	17650 GENERATIONS DR SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This survey was for the Investigation of Complaint IN00159118. Complaint IN00159118 - Substantiated. No deficiencies related to the allegations are cited. Survey date: November 13, 2014 Facility number: 001148 Provider number: 001148 AIM number: N/A Survey team: Honey Kuhn, RN Census bed type: Residential: 61 Total: 61 Census payor type: Medicaid: 50 Other: 11 Total: 61 Sample: 3 Wood Ridge Assisted Living was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00159118. Quality Review 11/14/14 by Lisa McColly	R 000		